

RHEUMATOID ARTHRITIS/PSORIASIS
(ENBREL[®], HUMIRA[®], KINERET[®], AMEVIVE[®], RAPTIVA[®])
PREAUTHORIZATION REQUEST
PHYSICIAN FAX FORM



ONLY the prescriber may complete and fax this form.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit www.bcbsil.com

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	

INSURANCE INFORMATION

BCBS ID Number:	Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:
Medication Requested:
<p>1. Is the patient currently treated with the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment with the requested medication started? _____</p> <p>2. If the patient is currently prescribed the requested medication, has the treatment been beneficial in achieving remission of the disease or decreasing symptom severity? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. For renewal of Amevive, has there been a minimum of 12 weeks since the end of the previous course of Amevive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Please list all other medications the patient is currently taking for treatment of this diagnosis. _____ _____</p> <p>5. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.) _____ _____</p> <p>6. If the patient has been previously treated with another biologic (Enbrel, Humira, Kineret, Amevive, Raptiva, Orencia, Remicade, or Rituxan), will this drug be discontinued before the requested medication is started? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Please include any additional information that should be considered with this review. _____ _____</p>

Please fax or mail this form to:
 Blue Cross and Blue Shield of Illinois
 c/o Prime Therapeutics LLC, Clinical Review Department
 1020 Discovery Road, No. 100
 Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130

Phone: 800.285.9426

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